

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 titled Medical Dispute Resolution of a Medical Fee Dispute, and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 7-25-03.

The IRO reviewed myofascial release, joint mobilization, gait training, office visits, neuromuscular re-education, range of motion, and therapeutic exercises on 4-1-03 and 4-2-03.

The Medical Review Division has reviewed the IRO decision and determined that the **requestor prevailed** on the majority of the medical necessity issues. The IRO agreed that joint mobilization, myofascial release, and two units of the therapeutic exercises were medically necessary. The IRO agreed with the previous determination that gait training, office visits, range of motion, and neuromuscular re-education were not medically necessary. Therefore, upon receipt of this Order and in accordance with §133.308(r)(9), the Commission hereby orders the respondent and non-prevailing party to **refund the requestor \$460.00** for the paid IRO fee. For the purposes of determining compliance with the order, the Commission will add 20 days to the date the order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division. On 6-17-04, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Codes 97122, 99213 and 97113 were billed for dates of service 7-30-02 and 9-17-02 and denied by the carrier as "T – treatment guidelines". The treatment guidelines were abolished by statute effective 1-1-02; therefore, these services will be reviewed per the 1996 Medical Fee Guideline.

Recommend reimbursement as follows:

- Code 97122 – The MAR is \$35.00 per each 15 minutes. Requestor is seeking \$37.00. Recommend \$35.00.
- Code 99213 – The MAR is \$48.00. The carrier paid \$5.10. Recommend additional reimbursement of \$42.90.

- Code 97113 – The MAR is \$52.00 per each 15 minutes. Requestor billed 3 units. Recommend reimbursement of $\$52.00 \times 3 = \156.00 .

Code 97110 billed for date of service 12-20-03 was denied as “F – fee guideline MAR reduction. RATIONALE: Recent review of disputes involving CPT code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes “one-on-one”. Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division (MRD) has reviewed the matters in light of the Commission requirements for proper documentation. The MRD declines to order payment for code 97110 because the daily notes did not clearly delineate the severity of the injury that would warrant exclusive one-to-one treatment.

Code 97113 billed on date of service 12-27-02 had no EOB. Per Rule 133.307(e)(2)(B), the requestor did not submit convincing evidence of carrier receipt of the provider request for an EOB; therefore, no additional reimbursement recommended.

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) for dates of service through July 31, 2003;
- Plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order.

This Order is applicable to dates of service 7-30-02 through 4-1-03 as outlined above in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 4th day of November 2004.

Dee Z. Torres
Medical Dispute Resolution Officer
Medical Review Division
Enclosure: IRO Decision

July 12, 2004
Amended November 1, 2004

David Martinez
TWCC Medical Dispute Resolution
4000 IH 35 South, MS 48
Austin, TX 78704

Patient:
TWCC #:
MDR Tracking #: M5-04-2666-01
IRO #: 5251

Ziroc has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to Ziroc for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

Ziroc has performed an independent review of the care rendered to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Doctor of Chiropractic. The reviewer is on the TWCC Approved Doctor List (ADL). The Ziroc health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to Ziroc for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ underwent physical medicine treatments and synvisc injections after injuring his left knee at work on ____.

DISPUTED SERVICES

Under dispute is the medical necessity of aquatic therapy (97113), myofascial release (97250), joint mobilization (97265), office visits (99213), gait training (97116), ROM measurements (95851), neuromuscular re-education (97112) and therapeutic exercises (97110) from 02-28-03 through 04-04-03.

DECISION

The reviewer disagrees with the prior adverse determination regarding myofascial release (97250), joint mobilization (97265) and two units of therapeutic exercises (97110) for the dates of 04-01-03 and 04-02-03.

The reviewer agrees with the prior adverse determination regarding all other services.

BASIS FOR THE DECISION

Myofascial release, joint mobilization and a maximum of two units of therapeutic exercises on 04-01-03 and 04-02-03 qualify as being medically necessary due to the injection that was performed on 03-31-03. However, there was no documentation supplied to support the medical necessity of four units of therapeutic exercises for the knee.

Ziroc has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. Ziroc has made no determinations regarding benefits available under the injured employee's policy

As an officer of ZRC Services, Inc, dba Ziroc, I certify that there is no known conflict between the reviewer, Ziroc and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

Ziroc is forwarding this finding by US Postal Service to the TWCC.

Sincerely,

Nan Cunningham
President/CEO
CC: Ziroc Medical Director